Initial Comments to the Federal Communication Commission 47 CFR Part 54 WC Docket 17-310, FCC 17-164 Promoting Telehealth in Rural America

Summary of Requested Changes

- Telecommunication Program
  - Critical Access Hospitals and tribal clinics - always eligible
  - Maximum Funding 90% of the cost of the service
  - Urban Documentation must be ILEC based
  - ILEC must be contacted and offered to bid on all services (baseline cost)

- Funding Priorities
  - Priority Level One
    - Telecommunication Program 100% fully funded
    - Healthcare Connect Individual Internet 100% fully funded
  - Priority Level Two
    - Healthcare Connect Individual (non-Internet) & Consortium
    - Limited Urban Hospital Support to $50,000 per year
    - Support Based on RHC CAP less Priority One

- Support for Leased Communication Services Only
  - No support for equipment
  - No support infrastructure build out

- Invoicing Deadlines
  - Traditional 12 months after the end of the funding year
  - Healthcare Connect 12 months after the end of the funding year

- Consortium Reporting
  - Disclose Funding Provided to Rural Locations
  - Disclose Funding Provided to Urban Locations

- Non Eligible Urban Areas
  - Redefine Urban Areas based on Cities with 50,000+ inhabitants
  - Establish a Standard Urban Distance from the center of the city
  - GPS coordinates used to verify rural or urban status

It's the RURAL HEALTHCARE PROGRAM ---- Right?

In 1996, Congress updated the Telecommunication Act to provide for competition in markets and did away with the outdated concept of local utilities which receive a fair return on their investment. Urban Areas with a higher density of individuals and businesses would benefit from the competition. Costs would be reduced for those lucky enough to be in those competitive areas. Rural areas would be out in the cold.

LEVEL THE PLAYING FIELD. That is the intent of the Universal Service Fund. The Federal USF is to be used to help balance out the effects of rural areas not being able to take advantage of urban area rates. This is the basis for the RHC Telecommunication Program. Rural Costs less USF Support = Cost of the same Service in Urban USA. This is a wonderful and simple idea to create a balance.

This common sense and practical idea is under fire. Why, not enough money allocated to the program was being used. The FCC decided to shake things up and see how much money they could pass around. Hurricane Katrina, in 2005, provided the FFC the first opportunity to fund urban areas under the concept of displaced citizens from the gulf coast. 2007 brought about the Pilot Program which was designed to break all the rules. The rules about how funding should be wisely used. This provided hospitals in urban areas, which needed no financial help, funding to build fiber services between urban sites while providing little to the rural sites.

The lesson learned from the Pilot Program, if you pay 85% of the cost of the service, people will get on board and they will take advantage of the program. The analysis of the Pilot Program was very slanted and again all involved could boast, "what a wonderful thing we have done." Now Comes the Healthcare Connect Fund Consortium, "what a wonderful thing we have done." Lets add Skilled Nursing Homes, "what a wonderful thing we have done." Let's focus on what is important. Critical Access Hospitals, Rural Hospitals and Clinics serving rural America.

WE NEED TO RETURN TO THE CORE PRINCIPLE - Provide financial support based solely on the cost of the service. As competition, in the form of new service providers, spreads into smaller markets costs for services will decrease. Less funding will be required as the playing field comes closer and closer to rural America. Establishing a program where every location, urban and rural, receives 65% support (forever) there will be a expanding need for funding (forever).

Urban areas receive 65% support for services which are very competitively priced. Their rate establishes the baseline for support in the telecommunication program. Exceeding the funding CAP redirects money from rural sites to urban sites.

Several steps need to be taken to provide financial funding stability to Rural Hospitals and Clinics.

- Telecommunication Program
  - Critical Access Hospitals and Tribal Clinics - always eligible
  - Non Profit Hospitals and Clinics in Rural Areas
  - Maximum Funding 90% of the cost of the service
  - Urban Documentation must be ILEC based
  - ILEC must be contacted and offered to bid on all services (baseline cost)

With the Funding cap pierced, protection needs to be provided to the healthcare providers and also establish controls in funding. Health Care Providers in Rural Areas in addition to all Critical Access Hospitals, Federal Qualified Rural Health Centers and Tribal Clinics would be eligible for support. Support would be limited to 90% of the cost of the service (NSS - Alaska service would be greatly impacted), Urban Rate documentation needs to be provided from an independent source or local telco which reflects the true urban cost of the service (NSS). The local phone companies need to play a role in providing at a minimum a quote for services as a comparison.

- Funding Priorities
  - Priority Level One
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Create two priority levels which protect the most vulnerable health care organizations. Providing full funding of services for Priority Level one organizations in Rural Areas. This allows the organizations to budget funds for services without the unknowns brought about by reduction from exceeding the funds cap.

Priority Level Two allows for the full use of all program funds on a prorated basis.

- Support for Leased Communication Services Only
  - No support for equipment
  - No support infrastructure build out

The expansion of the program into these areas at this time when the funding cap is being exceeded needs to be eliminated to focus on service support.

- Invoicing Deadlines
  Traditional 12 months after the end of the funding year
  Healthcare Connect 12 months after the end of the funding year

This requirement puts an undue burden on the carriers to meet deadlines which have no true value. USAC has no problem taking excessive time to review appeals. This change does not benefit the health care provider should there be an issue in the service(s). One full year after the end of funding year would provide time should the FCC find they want to do a rollover of funds. From the previous year.

- Consortium Reporting
  Disclose Funding Provided to Rural Locations
  Disclose Funding Provided to Urban Locations

The public should be able to determine quickly and easily the funds going to urban organizations verses rural locations by HCP number and associated funding amount per service.

- Non Eligible Urban Areas
  Redefine Urban Areas based on Cities with 50,000+ inhabitants
  Establish a Standard Urban Distance from the center of the city
  GPS coordinates used to verify rural or urban status

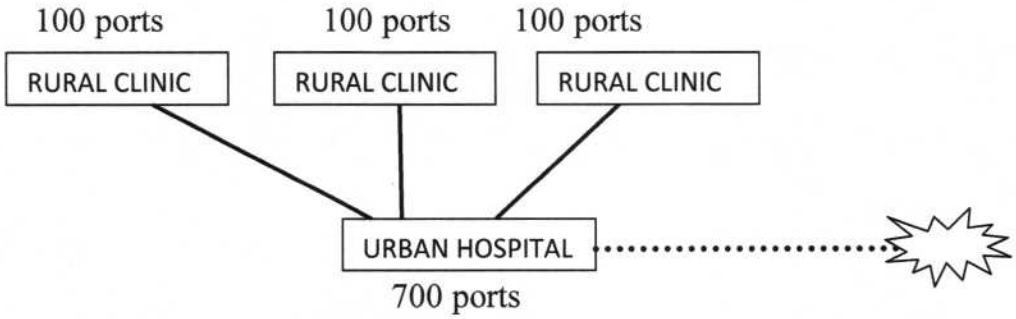
What is an urban Area? That has been the issue since the program began. The initial determination was to use Metropolitan Statistical Areas (MSA) and include the entire county as urban (goldsmith modification). However, we now have Metropolitan and Micropolitan Areas and the usefulness of the MSA has ended. It is not possible for the average person to determine what is or is not rural as the only method has been the ffiec and now the Texas A&M web site. Pop in an address and get a number. But often the location is logically rural but somehow in the minds of the geography PhDs there are some threads. But, we never know.

Let's go back to what the goal. Urban Areas will have competition and those areas that do not will need help with funding. As a cutoff, cities with populations of 50,000 people or more. More than 50,000, no funding. Determine the center of the city. Then create an urban zone similar to the Standard Urban Distance (SUD) created by USAC for each state. Health Care locations outside this areas are eligible for support.

It might be possible, a location outside the Urban Area would qualify for support. If the location now has multiple service providers, the cost for services should be lower and more likely will reflect the cost in the urban area. Support would be appropriate for the location. Less funding required as the level playing field expands.

The present HCF Program would continue to provide support (65%) at levels that are not appropriate.

PROPORTIONAL FUNDING In the case where Hospitals or Data Centers are the hub of common services costs should be allocated.



In the representation above, the dedicated connections to the Urban Hospital from the Rural Clinics are funded as usual. The Dashed Line represents a dedicated Internet Connection. Using cost allocation, only 30% of the common service is actually used in direct support of the rural operations. Therefore, support should be based on 30% not 100% as allowed under the HCF.

URBAN CREEP or NOT The Upper Peninsula of Michigan is simple to find on your map. Just above Wisconsin surrounded by lakes. 311,000 people live here. But, I want to talk about our urban city or Marquette. Not eligible as the county has obviously grown out of control, a massive urban setting. The numbers for the City of Marquette 19,316 (1995 yr) verses 20,570 (2015 yr) the county of Marquette 71,262 (1995 yr) verses 67,215 (2015 yr). The population has gone done but somehow we have become Urban. Don't know how this happened because it's all behind the curtain at Texas A&M.

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